RESPONSES TO HARD COPY COMMENTS ON 1115 WAIVER APPLICATION

1. Maureen Bertrand, NHA, Rowan Court Health & Rehabilitation Center

Comments on Eligibility Criteria for the Highest Needs Group:

Step2. Extensive or total assistance needs to be defined. Are we following the MDS guidelines?

Reply: Definitions will be provided in the operating policies and procedures. Yes, we will be following the MDS guidelines.

Step 3. Severe Impairment with decision-making skills or a moderate impairment with decision-making skills. Nowhere in this document do we mention medications and the need to monitor because of medications. Especially in this category, many individuals have behaviors controlled with the use of medications. This question needs to be asked, but not only in reference to psychiatric disorders.

Reply: Individuals who meet the Step 3 criteria *("Does the individual have a severe impairment in decision making skills or a moderate impairment with decision making skills and one of the following behavioral symptoms/conditions that is not easily altered?")* would have a level of impairment that would include the need for medication management and monitoring and therefore be eligible for the Highest Need group.

Step 4. Under Ventilator/Respirator please add Bipap or Cpap (this is oxygen needs). These types of patients need to be monitored and often times adjustments to the amount of oxygen received must be made. Under skin ulcers we should be questioning the use of wound vacs.

Reply: Step 4 includes a limited list of conditions and treatments based on the Medicare Prospective Payment System (PPS). The Department wanted to ensure that individuals who had been receiving care under Medicare PPS would be able to receive the same type of care once their Medicare benefit had run out, assuming they were financially qualified for the 1115 Waiver. Step 5 covers additional conditions that would qualify an individual for the Highest Needs group. Please note that the list of conditions in Step 5 is not an exhaustive list.

Step 5: Add with Aphasia/Dysphasia, these types of patients are at risk for aspiration and should not be left unattended during meals.

Add to pneumonia/COPD and add to Cerebral Palsy chest Physical Therapy. These types of patients often need to be assisted with the loosening of secretions or they will develop a secondary pneumonia.

Add wound vacs to this list as well as suprapubic or Foley catheters. Often these devices need changing or monitoring.

Another concern would be the cardiac patient who needs close monitoring for CHF, weight gain and angina.

Response: the list is Step 5 is not meant to be all inclusive. *("Does the individual have an unstable medical condition that requires skilled nursing assessment, monitoring and care on a*

***daily basis** related to conditions or treatments including, but not limited to, the following?"*)
Please note that the unstable medical condition must result in a daily need for skilled nursing assessment, monitoring and care.

2. Anne Dilley, Champlain Valley Agency on Aging Case
Comments:

- "While the $10,000 increased resource limit looks good, I am concerned about the logistics of spending down to $2,000 in the form of co-payments. Is this in addition to patient share payments to providers?"

Reply: Individuals who elect to receive their care at home will have the increased $10,000 resource limit. Patient shares for individuals in the Highest Need and High Need groups will be calculated as they are today. Individuals in the Moderate Need group might have a co-payment but no patient share.

- "While DA&D "expects very few instances of persons found presumptively eligible who are ultimately determined to be ineligible," it doesn't indicate that if such an occurrence should happen, other than those "who knowingly mislead or misinform," that DA&D will reimburse the provider."

Reply: DA&D will cover the cost to the provider of services provided under the 1115 Waiver, if the presumptive eligibility determination for an individual turns out to be in error. Note: the final Waiver application no longer contains the language about "who knowingly mislead or misinform", since others correctly pointed out that it would be difficult to prove that an individual had knowingly misled or misinformed the Department.

- "I am concerned with the amount of assessments that the client has to go through – one for presumptive eligibility by the DA&D assessor, another by a DA&D employee (the initial assessment of his/her clinical and social support needs) and a third (the ILA) by the Case Manager."

Reply: The initial assessment, both for presumptive eligibility and the assessment of an individual's clinical and social support needs, will be done by the same DA&D employee. This information will be used to determine eligibility and to develop the initial plan of care so services can start as soon as possible. The DA&D employee will work closely with the local case management agencies and information will be shared between the DA&D staff person and the case manager. This information sharing will help both the DA&D employee and the case manager and should ensure that the consumer does not have to repeat any known information.

- "Whether or not case management services are necessary and are reimbursed is confusing. When partial service plans are implemented, it appears that the Case Manager may not be reimbursed for services. However, on page 27, it states that "all participants in the demonstration will have a designated case manager." On page 13 it states that all Demonstration enrollees will be eligible (but not required to utilize?) for case management services. And on page 14, it states certified case managers will meet, face-to-face, with each Demonstration enrollee at least monthly. Clarification is needed here."

Reply: We feel that case management is integral to ensuring that individuals receive the right services, in the right amount to meet their assessed needs. Therefore, we are structuring this LTC program so everyone receives case management. We still need to work through some of the details, e.g. we cannot replace existing case management services provided under the Older Americans Act or other sources with case management paid for through the 1115 Waiver. We also have not determined whether an enrollee can elect to refuse case management services and still participate in this waiver. Individuals would get the services they need; however, if sufficient funds have not been saved to serve everyone in this group, we will serve fewer people. If there are not sufficient funds to provide an individual (other than the Highest Needs entitlement group) with the full range of services called for in the plan of care, the individual would still receive case management and that service would be reimbursed.

- "I am concerned that the draft states that Vermont will substantially increase the responsibilities of the Long Term Care Ombudsman Program without any mention of an increase of staff for this already thinly-stretched group."

Reply: The expansion of the LTC Ombudsman Program to include home-based care recipients is an important element of the Quality Assurance/Quality Improvement component of this initiative. We have every intention of providing additional funds for this program.

- "While I have no specific misgivings about long term care insurance, it seems that the group that becomes eligible for this program is not likely to have the resources to obtain such insurance."

Reply: The public information about long-term care insurance would not be targeted just to individuals who are potentially eligible for the 1115 Waiver. This message would be directed to a much larger audience.

- "In the not too distant past, DA&D's direction seemed to be towards more local control and it appears that the proposed 1115 Waiver goes in exactly the opposite direction with much more control from the state, even to facilitation of our team meetings. We are concerned that the excellent collaboration we have established will be diminished."

Reply: Since this new LTC program is charting new territory, and the State is at-risk financially for the cost of the services delivered under this program, it important and necessary for the State to be very actively engaged in the initial assessment and plan of care and in approving changes to plans of care. We believe that having DA&D staff fully engaged at the local level will improve communication and ensure that services are implemented as quickly as possible. Facilitation of the local waiver teams by DA&D staff will ensure that information from DA&D is delivered as quickly and accurately as possible.

- "And lastly, it is impossible to expect the Chittenden/Grand Isle Medicaid Waiver Team to review all active cases every month. We have over 200 participants presently."

Reply: We would like to take this opportunity to clarify our statements on this issue. We expect that the team will be aware of all the cases; however, the team would only discuss those cases in which the case manager or other team member feels there is a reason or concern that warrants

input from the rest of the team – an approach we understand is already used by the Waiver Teams across the state.

- "We spoke of this draft at our Medicaid Waiver Team meeting this morning and are concerned that DA&D is attempting to fix something that isn't broken, that we are presently providing quality services to the elderly and disabled in our community. We don't understand how the 1115 Waiver is going to increase participating since we expect participants to be even more needy than those on the present HCBW."

Reply: There is no question about the quality of services being provided to elders and younger adults with disabilities in the Chittenden/Grand Isle communities. The members of the Waiver Team should be very proud of the work you all do every day; however, one of the primary goals of this waiver proposal is to help even more individuals access those services without having to wait for a waiver slot to become available. By broadening the entitlement to either home- and community-based or nursing facility care, Vermonters who qualify for that level of care will be able to choose the most appropriate setting to meet their needs without having to choose between waiting in line for community-based services or entering a nursing facility to receive the help they need.

One of our primary assumptions is that as more people choose home- and community-based services, (which costs less to deliver than care in a nursing facility), the dollars saved can be used to expand home- and community-based options and serve even more people.